STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 FAIRGROUNDS RD TIPTON, IN46072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00091876. Complaint IN00091876 - Substantiated, Federal/State deficiencies related to the allegation are cited at F-223, F-225, F-226, and F-329. Survey dates: June 13 and 14, 2011 Facility number: 000505 Provider number: 155556 AIM number: 100266350 Survey team: DeAnn Mankell, R.N. Census bed type: SNF: 15 SNF/NF: 115 Total: 130 Census payor type: Medicare: 12 Medicaid: 89 Other: 29 Total: 130 Sample: 9 These deficiencies also reflect state findings cited in accordance with 410 IAC	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 FAIRGROUNDS RD TIPTON, IN46072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	16.2. Quality review completed on June 20, 2011 by Bev Faulkner, RN			
F0223 SS=D	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview, the facility failed to ensure verbal abuse did not occur to 3 residents in a sample of 3 allegations of verbal abuse for 3 of 3 residents in a sample of 9 (Residents A, H, and I) . Findings include: 1. During an interview with CNA #1 and CNA #2, on 6/14/11 at 3:30 A.M., they indicated LPN #1 had been rude and disrespectful to Resident H one night. They could not remember the night this had happened. CNA's #1 indicated LPN #1 had yelled so loudly at Resident H that she could hear him from the next hall. CNA #1 said LPN #1 had told Resident H she could not have her pain pill for another hour as she had just had an Ativan (an anti-anxiety medication) and that she would have to wait for the Oxycodone	F0223	Please accept the following credible allegation of compliance to the deficient practice cited under tag F223, of which ALL residents had the potential to be affected by. It is the policy of Miller's Health Systems that all residents have the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. Miller's Health Systems has policies and procedures in place that ensures that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the Administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). Immediately upon learning of these allegations, both employees in	06/22/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 FAIRGROUNDS RD TIPTON, IN46072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(pain medication). Unit Manager #1 was listening to the interview with CNA #1 and CNA #2. Unit Manager #1 indicated she was unaware of the exchange between LPN #1 and Resident H. CNA #1 indicated she had told the night supervisor of these concerns the night this had occurred. During an interview with the (Director of Nurses) DON on 6/14/2011 at 3:50 A.M., she indicated no one had told her of LPN #1's yelling at Resident H. She indicated she was aware of his treatment of other staff members, but not to the residents. She indicated LPN #1 had worked at the facility for a few weeks. During the daily conference on 6/14/11 at 4:20 A.M., the DON and Unit Manager #1 indicated they both indicated they were unaware of the allegation of verbal abuse until the interview that night at 3:30 A.M., but they indicated they were going to suspend LPN #1 right now and begin an investigation into the allegation of verbal abuse. During an interview with Resident H on 6/14/11 at 1:35 P.M., she indicated LPN #1 would not give her the pain pill at 11:00 P.M., when she had asked for it, but had told her she needed to wait for it. She		question were suspended pending investigations. None of the three residents involved, (A), (H) or (I), were found to have been negatively affected by either employee's behavior towards them. Reports were submitted to ISDH and to the Ombudsman and a facility investigation began immediately. Upon investigating, it was found that no other residents were affected by these incidents nor were there any further reports made of resident mistreatment in any form by these two employees or any other. Miller's Merry Manor regrets these incidents occurred, however, the Director of Nursing and Administrator acted swiftly and appropriately upon hearing of the allegations. Thorough investigations were completed which ultimately led to the discharge of one employee (LPN#1) and a written reprimand of another (RN#1). On April 22nd, 2011, all staff were in-serviced on preventing, recognizing, and reporting resident abuse. The facility will conduct another in-service on or before 6/28/11 which will include review of our abuse/neglect policies and further customer service training. The facility will continue to conduct resident abuse re-education on an ongoing basis and at least semi-annually. The social service staff or designee will speak with a total of 6	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 FAIRGROUNDS RD TIPTON, IN46072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	said she told him she needed it now, but he still wouldn't give it to her. She said he had not raised his voice to her, but later in the conversation she indicated LPN #1 had raised his voice to her when she had raised her voice to him. When he told her she would have to wait for her pain pill as he would not give it to her with the sleeping pill, she indicated she had told him to "Go to h---," because he had made her mad as she was hurting badly and she had told him she hurt. She indicated she could have four pain pills a day and she usually only took three in a day as she wanted to make sure she could have one pain pill when she went to bed so she could sleep. She said he gave her the pain pill an hour later, but that she had to lay in bed in pain for an hour in pain as she "was hurting like mad" and she couldn't sleep because of the pain. She indicated the sleeping pill didn't do much good without the pain pill. Resident H's clinical record was reviewed on 6/14/11 at 3:10 P.M. Resident H's diagnoses included, but were not limited to, chronic pain, bi-polar disorder, depression, chest pain, diabetes, coronary artery disease, congestive heart failure, and atrial fibrillation. Resident H's quarterly MDS (Minimum		residents and/or family members weekly for four weeks and then monthly thereafter using the Abuse and Neglect Review Quality Assurance Tool (Attachment # 1A).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 FAIRGROUNDS RD TIPTON, IN46072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Data Set) assessment, dated 4/7/11, indicated she was independent in decision making ability. On 6/14/11 at 3:30 P.M., the ADON provided a phone interview she had conducted with the night supervisor in which she noted CNA #1 and a new employee had told her LPN #1 was disrespectful of Resident H, but she felt CNA #1 was venting about their night rather than making accusations. The facility provided a copy of a written interview on 6/14/11 at 4:00 P.M., which was conducted on 6/14/11 by the DON with RN #2. RN #2 indicated she "heard LPN #1 yell from the nurses' station down the hall to Resident H that she could not have a pain pill because she had just gotten her Ativan and it was not time. She states that he is ... impatient with residents. She believes that he has no compassion for his residents. RN #2 states that if she believed he was abusing residents she would have notified myself and (name of the administrator) immediately." The DON and Administrator conducted a telephone interview with LPN #1 on 6/14/11 at 5:40 P.M. LPN #1 said he had not raised his voice or yelled at Resident H. He said he did give Resident H her			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 FAIRGROUNDS RD TIPTON, IN46072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	pain pill, but he would not give it to her when he gave her the sleeping pill, because he "didn't feel comfortable giving them both at the same time." He said he made her wait for the pain medication, but he had given her the sleeping pill and a different pain medication. He indicated he didn't contact the physician or have someone on the day shift clarify with the physician if he could give both medications at the same time. He said she would seldom say she was in pain, she would just ask for the pain medication. At the end of the conversation, the Administrator told LPN #1 he was still suspended and he would call him the next day. 2. During an interview with CNA #1 and CNA #2, on 6/14/11 at 3:30 A.M., they indicated Resident I, didn't want LPN #1 taking care of her, as Resident I thought LPN #1 was rude. During an interview with the (Director of Nurses) DON on 6/14/2011 at 3:50 A.M., she indicated no one had told her of LPN #1's "rudeness" toward the residents. She indicated she was aware of his rudeness to other staff members, but not to the residents. During an interview with Resident I on 6/14/2011 at 2:15 P.M., she indicated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 FAIRGROUNDS RD TIPTON, IN46072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	LPN #1 was "disrespectful" and used a tone as voice that was like a command. She indicated when he would come into her room to answer her call light, he would say "What do you want!" as a command, not as a question. Then when she would tell him what she wanted, he would tell her he would get a CNA and not assist her. Most of the time he would not tell the CNA's that she needed help and she would have to put the call light on again. He would not assist her into the bathroom. She indicated "I don't want him to work my hallway. I don't feel like I'm respected. He makes me feel like I bothered him." She indicated one night she asked him to reposition her legs and he "threw my legs on the bed and left the room." She further said "I feel uncomfortable when LPN #1 works at night." She indicated she had not told anyone of how he treated her, but the CNA's all knew about him. Resident I's clinical record was reviewed on 6/14/11 at 3:30 P.M. Resident I's diagnoses included but were not limited to multiple sclerosis, depression, diabetes mellitus, paraplegia, and muscle spasms. Resident I's quarterly MDS (Minimum Data Set) assessment, dated 4/12/11,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 FAIRGROUNDS RD TIPTON, IN46072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated she was independent in decision making ability. The DON and Administrator conducted a telephone interview with LPN #1 on 6/14/11 at 5:40 P.M. LPN #1 said he "always answers the residents call lights and attends to their needs all the time." He indicated he had never forgotten to return to assist a resident and "I make sure to answer the call light." 3. During an interview with CNA #1 and CNA #2, on 6/14/11 at 3:30 A.M., they indicated RN #1 had been rude and disrespectful about Resident A and had said within her hearing that she was "addicted to pain medication" but that she had given Resident A her pain medication. During an interview on 6/14/11 at 3:50 A.M., with the DON, she indicated she was unaware of RN #1 making the statement in front of Resident A. During the daily conference on 6/14/11 at 4:20 A.M., the DON and Unit Manager #1 indicated they were going to suspend RN #1 right now and begin an investigation in the allegation of verbal abuse. Resident A was out of the building on 6/14/11 and was not interviewed.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 FAIRGROUNDS RD TIPTON, IN46072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The facility was conducting a continuing investigation of this allegation of verbal abuse. On 6/14/11 at 4:00 P.M., the facility provided a written statement made by RN #1 on 6/14/11 in which she indicated "I have voiced concerns that res. has not been adjusted to adequately control pain, but never was it said she was adicted (sic) to pain med." Review of the policy for "Resident Abuse," dated 6/13/2011, indicated "It is the policy of Miller's Health Systems that all resident have the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion.... C. Verbal Abuse - is defined as the use of oral, written and/or gestured language that willfully included disparaging and derogatory terms to residents or their families or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm, saying things to frighten a resident telling a resident that he/she will never be able to see family again, belittling residents....E. Neglect - means the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 FAIRGROUNDS RD TIPTON, IN46072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This tag relates to complaint IN00091876. 3.1-27(a)(1) 3.1-27(a)(3) 3.1-27(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 FAIRGROUNDS RD TIPTON, IN46072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to ensure all allegations of verbal abuse were reported to the administrator immediately for 3 of 3 allegations of verbal abuse toward 3 of 3	F0225	Please accept the following credible allegation of compliance to the deficient practice cited under tag F225, of which ALL residents had the potential to be affected by. It is the policy of	06/22/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 FAIRGROUNDS RD TIPTON, IN46072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	residents in a sample of 9 (Residents A, H, and I) . Findings include: 1. During an interview with CNA #1 and CNA #2, on 6/14/11 at 3:30 A.M., they indicated LPN #1 and RN #1 had been rude and disrespectful to Residents A, H, and I. CNA #1 indicated she had reported an incident regarding LPN #1 and Resident H to the night supervisor. The CNAs indicated they could not remember if they had reported the incident between RN #1 and Resident A or the way Resident I felt about the way she was treated by LPN #1. The CNAs indicated LPN #1 had yelled at Resident H and told her she would have to wait for an hour for her pain pill as he would not give it to her with her sleeping pill. They indicated RN #1 would say Resident A was "addicted" to pain medication within Resident A's hearing, but she would give Resident A her pain medication. They also knew that Resident I did not want LPN #1 taking care of her as he was disrespectful toward her. During an interview with CNA #1 and CNA #2, on 6/14/11 at 3:30 A.M., the CNAs indicated they had not told Unit		Miller's Health Systems that all allegations of suspected abuse are reportedly immediately to a supervisor who will then contact the Administrator and Director of Nursing. However, to avoid any future delays or confusion with abuse/neglect reporting, all such allegations will now be called in directly to the Administrator by the person making the claim. Their supervisor will also still immdiately be made aware. This will ensure that all reports of allegation are receiving immediate attention and any potential interference of a "middle man" not getting the report turned over to the Administrator timely will be negated. All staff were in-serviced on this new procedure on 6/22/11.To prevent a recurrence of this deficient practice, abuse/neglect in-services will continue on-going as needed and no less than semi-annually, which will address our reporting procedures. Furthermore, the social service staff will speak with a total of 6 residents and/or family members weekly for four weeks and then monthly thereafter using the Abuse and Neglect Review Quality Assurance Tool (Attachment #1A) to help ensure that no episodes of abuse/neglect have occurred and gone unreported.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 FAIRGROUNDS RD TIPTON, IN46072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Manager #1, the DON, or the Administrator of these incidents. Review of the policy for "Resident Abuse," dated 6/13/2011, indicated "5. Resident abuse: B.1.b. The individual who witnessed the incident shall immediately notify the Charge Nurse of the Nursing Unit which the resident occupies. If this is not feasible due to circumstances, the individual shall be responsible to notify any other nurse currently on duty.... c. The Charge Nurse is responsible to notify the facility Administrator and Director of Nursing Services immediately." This tag refers to complaint IN00091876. 3.1-28(c)			
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure facility staff followed written policy for the prohibition of mistreatment, neglect, and abuse of 3 of 3 allegations of verbal abuse toward 3 of 3 residents in a sample of 9 (Residents A, H, and I) .	F0226	Please accept the following credible allegation of compliance to the deficient practice cited under tag F226, of which ALL residents had the potential to be affected by. It is the policy of Miller's Health Systems that all allegations of suspected abuse are reportedly immediately to a supervisor who will then contact	06/22/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 FAIRGROUNDS RD TIPTON, IN46072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: 1. During an interview with CNA #1 and CNA #2, on 6/14/11 at 3:30 A.M., they indicated LPN #1 and RN #1 had been rude and disrespectful to Residents A, H, and I. The CNAs indicated LPN #1 had yelled at Resident H and told her she would have to wait for an hour for her pain pill as he would not give it to her with her sleeping pill. They indicated RN #1 would say Resident A was "addicted" to pain medication within Resident A's hearing, but she would give Resident A her pain medication. They also knew that Resident I did not want LPN #1 taking care of her as he was disrespectful toward her. During an interview with CNA #1 and CNA #2, on 6/14/11 at 3:30 A.M., the CNAs indicated they had told the night supervisor of LPN #1's yelling at Resident H. They could not remember if they had told the supervisor of the way Resident I felt or of RN #1 verbal remarks about her being addicted to pain medication. The facility had interviewed the night shift supervisor on 6/14/11 by telephone and had provided a copy of the interview at 3:30 P.M. The night supervisor had told the ADON she had been "approached		the Administrator and Director of Nursing. However, to avoid any future delays or confusion with abuse/neglect reporting, all such allegations will now be called in directly to the Administrator by the person making the claim. Their supervisor will also still immdiately be made aware. This will ensure that all reports of allegation are receiving immediate attention and any potential interference of a "middle man" not getting the report turned over to the Administrator timely will be negated. All staff were in-serviced on this new procedure on 6/22/11.To prevent a recurrence of this deficient practice, abuse/neglect in-services will continue on-going as needed and no less than semi-annually, which will address our reporting procedures. Furthermore, the social service staff will speak with a total of 6 residents and/or family members weekly for four weeks and then monthly thereafter using the Abuse and Neglect Review Quality Assurance Tool (Attachment #1A) to help ensure that no episodes of abuse/neglect have occurred and gone unreported.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 FAIRGROUNDS RD TIPTON, IN46072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	about 2 weeks ago by CNA #1 and a new employee about how they felt LPN #1 was disrespectful with Resident H. I felt more as if they were venting about their night rather than making accusations. They were telling me that he wasn't helping answer call lights on this particular night....was then questioned about any concerns mentioned to her by staff regarding RN #1 and Resident A and (name) stated 'no, nobody has ever came concerned or to complain about either one of them'." Review of the policy for "Resident Abuse" dated 6/13/2011 indicated "5. Resident abuse: B.1.b. The individual who witnessed the incident shall immediately notify the Charge Nurse of the Nursing Unit which the resident occupies. If this is not feasible due to circumstances, the individual shall be responsible to notify any other nurse currently on duty.... c. The Charge Nurse is responsible to notify the facility Administrator and Director of Nursing Services immediately." This tag refers to complaint IN00091876. 3.1-28(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 FAIRGROUNDS RD TIPTON, IN46072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to monitor the use of prn (as needed) pain medications for 1 of 4 residents reviewed for prn pain medications in a sample of 9 (Resident H). Findings include: 1. Resident H's clinical record was reviewed on 6/14/11 at 3:10 P.M. Resident H's diagnoses included, but were not limited to, chronic pain, bi-polar disorder, depression, chest pain, diabetes,	F0329	Please accept the following credible allegation of compliance to the deficient practice cited under tag F329, of which ALL residents had the potential to be affected by.Resident: S.P. prn pain medications were reviewed by physician on 6/15/2011 and plan of care updated. The nurse management team will review all physician orders for prn pain medications by 6/28/2011 to ensure orders include reason for use and if more than (1) type of pain medication is ordered the orders must indicate the must indicate what level of pain they are to be given for. Example: Tylenol for pain level 1-5, Vicodin	06/28/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 FAIRGROUNDS RD TIPTON, IN46072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	coronary artery disease, congestive heart failure, and atrial fibrillation. Resident H's quarterly MDS (Minimum Data Set) assessment, dated 4/7/11, indicated she was independent in decision making ability. Resident H's May 2011 medication orders were reviewed. Resident H had an orders for "Oxycodone 10 mg, 1 tab by mouth: Four times daily as needed for moderate pain" first ordered on 2/25/2011. The MAR for June 2011 was reviewed on 6/14/11 at 4:30 P.M. Resident H had received the Oxycodone (a narcotic pain reliever) only four times from 6/1/11 until 6/4/11 according to the June 2011 MAR. The June 2011 PRN Pain Management Flow Sheet indicated Resident H has been assessed for the Oxycodone two times for the administration and one time with follow-up of the Oxycodone from 6/1/11-6/4/11 to determine the effectiveness of the medication. The Controlled Substance Record for the Oxycodone 10 mg tablets indicated from 6/1/11-6/4/11, Resident H received 14		for pain level 5-9 etc... An all nursing in-service was completed on 6/22/2011 to review the facility policy for pain management. Charge nurses will assess pain levels upon admission/readmission, MDS assessment, nursing daily assessment, wound assessments, each time vital signs are taken, or with any resident non-verbal or verbal indications of pain. A pain scale of 1-10/picture scale is utilized to standardize the measurement of pain for each resident. Upon assessment and the determination that a resident is experiencing pain the resident's physician orders and the HCP interventions will be followed. If administration of prn pain medication is indicated the nurse will be responsible to document the administration of the medication on the MAR ; also, the location of pain and/or level of pain, the dose of medication administered the time of administration, and the evaluation of the effectiveness post medication administration within 30-60 minutes on the facility prn pain flow sheet. Additionally, we have 7/7/11 scheduled as a date that all nurses will receive further training on pain management from Risk Management Solutions. The unit manager or other designee will be responsible to complete daily audits of 10 residents using the QA tool "Pain	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 FAIRGROUNDS RD TIPTON, IN46072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	doses of the medication. She was given 3 or 4 pills a day. On 5/30/11, there was an order written for "Ultram (a pain reliever) 50 mg i (one) PO (by mouth) BID (2 times a day) Q (every) 4 hours PRN (as needed) c (with) Tylenol 500 mg. PO Q 4 hours PRN mild to moderate pain." The June 2011 MAR was reviewed. She received the Ultram and Tylenol on 6/1/11 and 6/14/11. The June 2011 PRN Pain Management Flow Sheet indicated Resident H had not been assessed for the Ultram and Tylenol on 6/1/11, 6/3/11, or 6/14/11. The notation on 6/1/11 indicated the medication was for elbow pain without a rating of the pain before or after the medication was administered. The notation on 6/3/11 indicated the medication was for elbow & hip pain without a rating of the pain before or after the medication was administered. There was a lack of a notation for the 6/14/11 dose of the medication. During an interview with the DON on 6/14/11 at 5:00 P.M., she indicated it appeared the staff was not assessing the level of pain and doing the follow-up for the pain control.		Assessment and Review" (Attachment 2A) for 14days, then 3 times weekly for 6 weeks, then weekly thereafter to monitor compliance. Any identified trends will be logged on QA tracking tool and reviewed in the monthly QA meeting to ensure ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	300 FAIRGROUNDS RD TIPTON, IN46072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-48(a)(3)			